ritedentist
COSMETIC & RESTORATIVE DENTISTRY

Patient Information and Consent

What is the reason for your visit today?

Patient Information

Name (First, Middle, Last)	Birth Date	Age	Social Security #

Birth Sex ☐ M ☐ F	Primary Care Provider

Mailing Address	Apt. #	City	State	Zip

Email Address	Primary Phone ☐ Home ☐ Cell	Okay to leave message? ☐ Yes ☐ No

Employer (or parent's employer if patient is a minor)	Work Phone

Preferred Language	RACE ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

EMERGENCY CONTACT	Name	Relationship	Primary Phone

Guarantor (Person responsible for payment)

Guarantor's Name	Guarantor Birth Date	Guarantor Social Security #

Preferred Pharmacy

Pharmacy Name	Pharmacy Location

Insurance | Please present your ID and insurance card to the receptionist.

PRIMARY INSURANCE CARRIER			SECONDARY INSURANCE CARRIER		
Insurance Company Name			Insurance Company Name		
Address			Address		
City	State	Zip	City	State	Zip
Phone	Policy Number		Phone	Policy Number	
Group Number / Name			Group Number / Name		
Insured Name & DOB			Insured Name & DOB		
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Dependent			Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Dependent		

Rite Dentist Financial Agreement

Statement of Financial Policy:

We are committed to providing you with the best possible care. Your clear understanding of our Financial Policy is important to our professional relationship. Our office payment policy is payment is due at the time of our professional services are rendered. In order to assist you, we provide you with the following payment options:

1. Cash, Check or Credit Card
2. Payment Plan (Through Care Credit)

Insurance: Due to unpredictability of insurance reimbursement for dental care, we are not able to accept your assignment of benefits as payment for your treatment. Processing of insurance claims will be done as a courtesy for immediate reimbursement. However, it will be your responsibility to pursue payment from your insurance company. We cannot accept insurance on your first visit. On subsequent visits, we will accept your insurance on the understanding that you must pay on major dental work (50%) of total fee. If your insurance company has not paid the full balance within 30 days, you will have 7 days to pay the balance. If your insurance company pays more than the balance due, we shall reimburse you.

Insurance is a contract between you & your insurance company. We are not a party to this contract. In order to provide excellent care to our patients our office is out of network with insurance companies. Although we bill all insurances and can accept them, we cannot become involved in disputes between you & your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual & customary" charges, etc., other than supply factual information as necessary. You are responsible for the timely payment of your account. Our office will assist you in obtaining insurance reimbursement to the best of our abilities.

Missed Appointments: Unless cancelled at least 48 hours in advance, our policy is to charge for missed appointments $100 per occurrence.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

* For my convenience, this office may release my information to my insurance company, and receive payment directly from them.

- I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
- If sent to collections, I agree to pay all related fees and court costs.
- Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
- I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.
- I will pay a fee for appointments broken without 24 hours notice.
- Treatment plans may change, and I will be responsible for the work actually done.

X_____ _____

Patient or Authorized Person's Signature Date

Patient Consent for Dental Treatment

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

1. Treatment to be Provided:
I understand that during my course of treatment that the following care may be provided: Examinations, X-Rays, Preventive Services, Restorations, Crowns, Bridges and other dental treatments. Patient Initials_____

2. Drugs and Medications:
I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Patient Initials _____

3. Changes in Treatment Plan:
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary. Patient Initials_____

4. I give permission to Rite Dentist to bill my dental insurance provider for the treatment provided, if applicable. Patient Initials _____

5. I agree to be contacted via email or SMS with information related to my visit such as a patient portal invitation, post-visit satisfaction survey, appointment or checkup reminders, health tips, or new services that relate to me or my family. Patient Initials_____

6. I give permission to Rite Dentist to take, use and share images and videos of my teeth and self for lab communication purposes as well as promotional and educational purposes. Patient Initials_____

Notice of Privacy Policy Practice has been posted on https://ritedentist.com/forms for review.

I have received a copy of the Notice of Privacy Practice and Financial Policy Notice. ☐ Yes ☐ No Initial _____

X_____ _____
Patient or Authorized Person's Signature Date

Rite Dentist Medical History Form

Patient Information

Name:	Birth Date:	Social Security #

Personal Health

How would your rate your current health? ❒ Excellent ❒ Good ❒ Fair ❒ Poor

Age:	Weight:	Height:	Ethnicity:
Date of last physical exam:		Reason for today's visit:	
Date of last dental care and former dentist:			

Check (✓) if you have had problems with any of the following:

❒ Bad Breath	❒ Loose teeth or broken fillings	❒ Sensitivity when biting
❒ Grinding Teeth	❒ Sensitivity to sweets	❒ Food collection between teeth
❒ Sensitivity to hot	❒ Clicking or popping jaw	❒ Sensitivity to cold
❒ Bleeding gums	❒ Periodontal treatment	❒ Sores or growths in your mouth

How often do you floss?	How often do you Brush?	
How often do you see a Dentist?	What type of toothbrush do you use?	
Would you be interested in straighter teeth with clear aligner therapy?	❒Yes	❒No
Have you had braces before?	❒Yes	❒No
Does your oral health concerns you?	❒Yes	❒No
Do you want whiter teeth? ❒Yes ❒No	Reducing snoring? ❒Yes	❒No

Medications: Please list all prescription and non-prescription medications, vitamins, home remedies, and herbs.

Medications/ Supplements	(mg per pill, doses per day)	Start Date	End Date

Have you ever been hospitalized for illness? ❒Yes ☒No

Allergies or reactions to medicines:

Surgical History

Please indicate whether you have had any of the following medical problems
(Include dates to indicate when the problem occurred

❒ Periodontal Disease	❒ Kidney disease
❒ Dental infections	❒ Kidney stones
❒ Root Canal	❒ Gallbladder stones
❒ Bleeding gums	❒ Pancreatic disease
❒ Heart Disease	❒ Gout
❒ Stroke	❒ Hepatitis
❒ High Cholesterol	❒ Liver Diseases
❒ Heart Arrhythmia	❒ Lupus
❒ Heart Valve Problem	❒ Rheumatoid Arthritis
❒ High blood Pressure	❒ Sjögren's Syndrome
❒ Pre-diabetes	❒ Autoimmune disorder
❒ Diabetes	❒ Polycystic Ovaries
❒ Mini-Stroke or TIA	❒ Thyroid Diseases
❒ Atrial Fibrillation	❒ Depression
❒ Aortic / Brain Aneurysm	❒ Suicide attempts
❒ Blood Clot in Legs	❒ Anxiety/Panic Attacks
❒ Bleeding/clotting problems	❒ History of Seizure
❒ Blood transfusions	❒ Migraine Headaches
❒ Anemia	❒ Osteoporosis
❒ High red blood cell count	❒ Alcoholism
❒ Leukemia	❒ Mental Disability
❒ Abnormal platelet count	❒ PTSD
❒ Stomach Ulcers	❒ Drug Use
❒ Chronic Heartburn	❒ HIV/AIDS
❒ Restless legs	❒ Cancer
❒ Sleep disorder	❒ Physical Disability

Social History

Tobacco & Alcohol Use

Cigarettes: ❒ Never ❒ Quit: date you quit smoking	❒ Current smoker(packs per day)
Other tobacco (check all that apply): ❒ Pipe ❒ Cigar ❒ Chewing tobacco ❒ e-cigarettes ❒ Marijuana	
Number of years you've used this tobacco :	
Are you interested in quitting? ❒ Yes ❒ No Have you tried to quit in the past ❒ Yes ❒ No	
Are you exposed to second-hand smoke? ❒ Yes ❒ No If yes, for how long?	
Do you drink alcohol? ❒ Yes ❒ No	If yes, how many drinks do you consume per week?
Does your alcohol consumption have you or others concerned? ☐ Yes ☐ No	

Caffeine intake

Coffee: cups/day	Tea: cups/day	Soda: cans/day	Diet ❒ Regular ❒
Do you drink energy drinks or take pills to stay awake? ☐ Yes ☐ No		specify	
Decaffeinated products? ❒ Yes ❒ No		If yes, specify / how much	

Exercise

Do you exercise regularly? ❒ Yes ❒ No	What kind of exercise?
Do you have any limitations to your ability to exercise? Please explain	

Socioeconomics

Occupation:	Employer:
Years of education/highest degree	Marital status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed
Spouse/partner's Name:	Who lives at home with you?
Where were you born? Where did you grow up?	
How many children do you have (Please provide names, gender, and ages.)	

Stress		
How would you classify your stress level at work/home? (Please check one) ❒ Low ❒ Medium ❒ High		
Do you feel anxious, angry, irritated or rushed? ❒ Yes ❒ No	How do you manage your stress?	
Do you meditate daily? ❒ Yes ❒ No If yes, how?		
Diet		
How do you rate your diet? (Please check one) ❒ Excellent ❒ Good ❒ Fair ❒ Poor		
Do you currently see a dietitian? ❒ Yes ❒ No If yes, how often?		
Name:	Contact:	
How many daily servings of the following do you have:		
Whole grains:	Fruits:	Vegetables:
Water:	Nuts:	Milk: what % Fat
How many times a week do you consume the following items?		
Eggs:	Fish:	Chicken / Turkey:
Red Meat:	Dairy Products:	Going out to eat:
Margarine:	Processed foods:	
Do you have any food allergies or food sensitivities? ❒ Yes ❒ No		
Please list any problems you have experienced with pregnancy or delivery:		
Please list ALL supplements		
Are you satisfied with your weight? ❒ Yes ❒ No	Do you have any specific weight goals?	
History for women		
How many times have you been pregnant?	How many deliveries:	miscarriages:
Please list any problems you have experienced with pregnancy or delivery		
Do you have osteoporosis (bone loss)? ❒ Yes ❒ No	No osteopenia (bone thinning)? ❒ Yes ❒ No	
Menopause? ❒ Yes ❒ No	Hysterectomy? [ ] Yes ❒ No If yes, when was it removed:	
Ovaries removed? ❒ Yes ❒ No	Do you have any history of gestational diabetes? ❒ Yes ❒ No	
Do you have history of high blood pressure or eclampsia with pregnancy? ❒ Yes ❒ No		
Travel History		
Any recent International Trave? ❒ Yes ❒ No		
If yes, what countries and dates of stay:	Any illnesses during or post travel?	

Review of symptoms
Please check any current problems you have on the list below

Constitutional:
❒ Fever/chills/sweats
❒ Unexplained weight loss/gain
❒ Brittle Nails
❒ Dry skin
❒ Change in Energy/increase weakne
❒ Excessive thirst or urination
❒ Swelling (Explain)

Ear/Nose/Throat/Mouth:
❒ Difficulty hearing
❒ Ringing in your ears
❒ Hay fever/allergies
❒ Bleeding gums
❒ Dental Cavities
❒ Painful teeth or gums
❒ Bad breath
❒ Root Canals
❒ Dental Implants

Cardiovascular:
❒ Chest pain/discomfort
❒ Palpitations
❒ Swelling in feet or legs
❒ Varicose veins
❒ Pain in exttremities with exercise

Skin:
❒ Acanthosis nigricans (Dark lines around neck or under arms)
❒ Skin tags
❒ Flattening of nail beds
❒ Skin infections

Genitourinary:
❒ Unusual frequency of unrination
❒ Increased urination at night that interrupts sleep
❒ Blood in urine

Respiratory
❒ Cough/wheeze
❒ Difficulty breathing
❒ Snoring
❒ Sleep apnea/CPAP
❒ Respiratory infection

Gastrointestinal:
❒ Abdominal pain
❒ Blood in bowel movement
❒ heatburn Nausea/Vomiting
❒ Diarrhea/consitipation
❒ Loss of appetite
❒ Weight loss
❒ Weight gain

Neurological:
❒ Stroke
❒ Headaches
❒ Light-headedness
❒ Momeory loss
❒ Loss of coordination
❒ Tingling, pain or numness in hands or feet

Psychiatric:
❒ Problems with sleep
❒ Depression
❒ Panic attacks
❒ Mania
❒ Anxiety
❒ Anger issues
❒ Short temper or impatience
❒ Unusual feeling of doom
❒ Suicidal thoughts
❒ Hopelessness and constant worry

Eyes
❒ Change in Vision (Explain)
❒ Dry Eyes/Irritation
❒ Hemorhage
❒Double vision
❒ Glaucoma (Treatment?)
❒Cataracts (Surgery?)

Muscle/Skeletal:
❒ Chronic joint problem
❒ Back problems
❒ Artificial joints
❒ Neck problems
❒ Spine problems
❒ Muscle injuries
❒ Arthritis
❒ History of bone fractures
❒ History of torn or nuptured tendons
❒ paralysis of any muscles
❒ Unusual muscle weakness
❒ Any muscle side effects from statins

Blood/Lymphatic:
❒ Easy bruising/bleeding
❒ Unexplained lumps
❒ Unusual bleeding
❒ History of blood clots
❒ History of anemia

Patient / Guardian Signature _____ Date: _____

Office Use Only

Reviewed by Doctor: _____ Date:_____